
DECEMBER 1950
R.N.
A JOURNAL FOR NURSES

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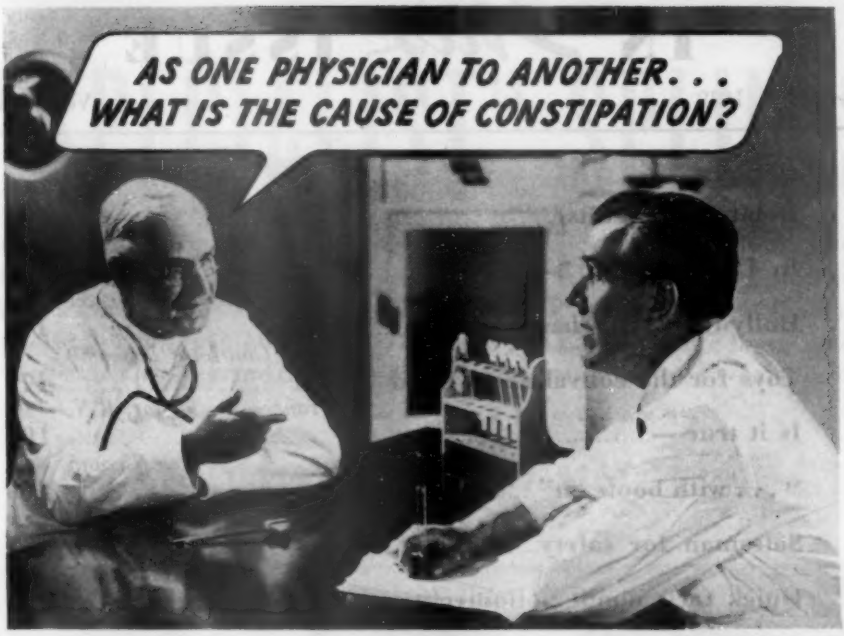

OBVIOUSLY, there is no single cause. Each case must be judged on its own merits. Anatomical differences, variations in diet and habit and specific pathological entities all enter into the cause. However, it is safe to say that faulty habit plays a role in the great majority of cases, and that loss of neuro-muscular tone is a very common secondary factor.

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IN *This* ISSUE

December, 1939 Vol. 3, No. 3

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A JOURNAL RN FOR NURSES

Circulation: 102,311 registered nurses. Copyright, 1939, Nightingale Press, Inc. Editorial and business offices at Rutherford, N.J. Dorothy Sutherland, managing editor. Mona Hull, R.N., editorial associate. Advertising representatives: Cyrus Cooper, Eastern manager, and Gladys Huss, Eastern associate, Graybar Bldg., New York City: J. M. Keene, Western manager, 870 Peoples Gas Building, Chicago.

Editorial and
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manager, 870

Debits and credits

THE FORGOTTEN MAN

Dear Editor:

It was with great interest that I read the article, "The War—and You," which appeared in the October issue.

Approximately a year ago I joined a medical detachment. I had to enlist as a private. Male nurses are not recognized in the military service, in contrast to female nurses, who rank as second lieutenants. The highest rank I can attain is that of sergeant.

This past summer I attended one of the Army camps during a two-week training period. My living quarters and conditions were exactly like those of the other enlisted men. Little regard was shown to the fact that I was a nurse.

The Army, Navy, and Red Cross are constantly preparing for major catastrophies, especially now, in view of the European situation. How much consideration is being given men nurses at this time? Will the several thousand male nurses gain recognition, or must they enlist as privates?

I believe our country would benefit greatly by securing their services, and by allowing them the rank of second or first lieutenant.

H. Richard Musser, R.N.
Philadelphia, Pa.

R.N. vs. P.N.

Dear Editor:

I should like to clarify my letter in the October issue.

We are just as interested in the graduate as the undergraduate. . .No affront was intended to the graduate. However, I did want to point out that there is a demand for undergraduates, and one might as well accept the fact. They need not encroach upon the field of the graduate, as the people who engage undergraduates cannot afford, or do not need a graduate.

I also want to state that more graduates should be employed for general duty, and at a better salary. Any extra expense incurred by the hospital might be passed on to the patient. Many people who do not need the full-time services of a graduate would gladly pay a small extra charge daily for the increased attention they would receive. This would mean more work for graduates on a permanent basis, which is really what they need.

Margaret Lytle, Registrar
Chicago Registry for Nurses
Chicago, Ill.

INFLUENZA TECHNIQUE

Dear Editor:

As an instructor of the Red Cross course in home hygiene, I am sure no registered nurse or any lay pupil of a home-hygiene class would take a pitcher of hot water and pour it over the patient's feet. The feet should be removed from the basin, the hot water added and tested, and the patient's feet replaced.

Safety has a very prominent place in the Red Cross program, and the procedure as illustrated is anything but safe.

Lillian M. Gillis, R.N.
Wood River, Ill.

Dear Editor:

In reading the article on influenza which appeared in October, I was surprised by the illustration showing an improvised incinerator.

Is it not considered quite safe and infinitely simpler to dispose of tissues in the toilet, along with liquid waste?

Burning might be necessary in rural districts. But it would seem easier and pleasanter to use the method taught by public-health nurses: Wrap tissues in clean newspaper and burn them in the kitchen stove or the back yard.

In regard to the second illustration, we hope the nurse is going to lift the patient's feet from the tub before she pours in that hot water!

Abby P. Choate, R.N.
Staten Island, N.Y.

[*The comments of these two alert readers were referred to the Home Hygiene*

NURSE . . . you know that the skin of babies is very susceptible to infection and needs to be fortified against bacterial invasion. Well, Mennen Antiseptic Oil markedly *reduces* the surface bacteria and helps protect baby's skin against infection. *But*. . .on the other hand, bacteria may readily multiply in ordinary oils, such as olive, mineral and cottonseed oil—and in most commercial oils, even though they be autoclaved.

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and Care of the Sick Service of the American Red Cross in New York, which released these pictures for publication. Says the director: "No good nurse...would remove a patient's feet from a hot mustard foot bath to add warm water. Such a procedure would chill the patient's feet and retard recovery. Also when the cooled wet feet were replaced in the warm water, it would feel uncomfortably warm. The correct procedure, as illustrated in the picture, is to add properly tested warm water from a pitcher, pouring the water slowly down the side of the basin..." The question of disposing of contaminated tissues narrows down to a difference of opinion. Most authorities agree, however, that burning is the safest method.—THE EDITORS]

SOURED?

Dear Editor:

This summer I was a patient in a hospital staffed entirely by graduate nurses, many of them middle-aged. My first impression of the general-duty nurses was their lack of makeup, and their sour expressions. In the five days I was in their care, never once did they give any service that wasn't requested...

Six weeks later I was rushed to a different hospital as an emergency case. This hospital had a training school and all the nurses who cared for me were students and very young. You cannot imagine the difference it made to see a bright, smiling nurse come into the room!

As a graduate, it seems to me a terrible judgment that students can nurse equally as well as graduates—and more cheerfully and gracefully. No doubt supervision played an important role in this difference. But graduates should not need supervision.

Helen Shields, R.N.
Chicago, Ill.

ARE MEN "LETHARGIC?"

Dear Editor:

I read with interest Mr. Galli's letter in October "Debits & Credits."

How can male nurses hope to be put on an equal footing with female nurses when they are content to remain unheard? By that I refer to their lack of support of our national organization, the A.N.A., and their own alumni. How can we expect recognition when so many men fail to support such groups?

I have tried unsuccessfully to persuade men to join the A.N.A., so that we could gain sufficient strength to form our own chapter. Such lethargy forecasts a dismal future...And until some aggressive individual in our own group comes forward with a plan to unite members...the fate of the male nurse will remain unimproved.

Edward J. Perreault, R.N.
Chicopee Falls, Mass.

CHARTING

Dear Editor:

In your October issue, Lillian Hall Bennett writes:

"Most of their nurses brought in a glass of milk and charted it. Then if they had to take it away, practically untouched, it never occurred to them that they were charting inaccurately."

Is there a training school in this coun-

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try that turns out such "trained" nurses? If the supervisors in these schools are so lax that such work on the part of a pupil nurse is not detected, and she manages to pass school and later Regents' examinations, there is most decidedly something wrong with the whole system. Such inaccuracy, in my opinion, could not fail to be noticed.

Elizabeth M. Shannon, R.N.
New York, N.Y.

SICK BENEFITS

Dear Editor:

You have published many worthwhile discussions, but I haven't seen any regarding financial security for sick and disabled nurses.

Is there a national or State relief fund for these nurses, or do they have to be dependent on the charity of relatives or the public?

R.N., Missoula, Mont.

[*Presumably, nurses must rely chiefly on private help or the assistance of their professional associations. The Social Security program does not include provision for nurses. . .Would readers like to see an article on this subject?*—THE EDITORS]

FROM A STUDENT

Dear Editor:

Gladys Jardine's letter on white shoes has aroused considerable comment among graduate and student nurses in our hospital. We need more co-workers like Miss Jardine to remind us of our negligence and point out how it mars the nurse's personality.

If you were a patient, how would you like a nurse to enter your room in a seemingly two-day-old uniform and dirty shoes, her whole appearance unbefitting a professional woman?

This kind of nurse is in a minority, but having been a patient, I have met a few already. Why do these few have to spoil and degrade the high standards of the nursing profession? Can we remedy this?

Nurses should show as much interest and exactitude in dressing for duty as we do for nightly "stepping out!"

Student Nurse
Hartford, Conn.

In UNIONS there is strength

The "labor problem" is nursing's most current controversy. Without taking sides, R.N. *presents here a frank discussion of developments to date. . . The editors believe this article contains facts every nurse should know. Readers who disagree with the opinions expressed, are invited to contribute their own views.*

BY ARTHUR J. GEIGER

• Nurses may soon find themselves classed, socially and economically, with female garment workers . . . Hospitals and their staffs will have become mere puppets whose strings will be held by labor leaders. . . . As for organized nursing, if it exists at all it will have all the force and effectiveness of the Ladies' Aid . . .

This is the fanciful nightmare currently giving some nursing leaders a bad case of the jitters, as more and more nurses enroll under the banners of trade unions.

How many of the nation's nurses already hold union cards is a question which these same leaders don't like to ask, and which labor probably wouldn't answer. A rough estimate places the figure at 5,000; certainly not more.

However, if union membership is low compared to total nurse-population, it cannot be denied that nurses' unions have made strides in the coastal cities where they originated about five years ago. In Seattle they are strong enough to emerge victorious from a labor war with municipal hospital authorities; in San Francisco, they boast some 800 members—about a third of the local profession; and in New York City, their stronghold, they claim 3,500 dues-payers [but not necessarily nurse-members] and chapters in 33 hospitals.

Flushed by these successes, labor's generals are now mapping a big push into the hinterland. As advance guard, the C.I.O. has established locals in nine States: California, Illinois, Indiana, Iowa, Michigan, Minnesota, Ohio, Pennsylvania, and Wisconsin. Organizers working out of regional offices, placed strategically throughout the country, are busily laying what they hope will be the groundwork for a national nursing-union network.

The family quarrel between the C.I.O. and A.F. of L. is being reflected in a similar split among unionized nurses. At present, the A.F. of L. holds the West Coast; the C.I.O. the East. No one can foretell what will happen when, and if, they meet in the middle.

To make a comparison of these two

organizations' aims as simple as possible, their platforms* have been grouped in the table that appears with this article. (See page 28.) It shows them in agreement on the consecutive eight-hour day, and collective bargaining (the exclusive right *of the union* to determine the nurse's conditions of service).

The A.F. of L. stresses a "living wage," with pay for overtime, and better living conditions. The C.I.O. wants a $1500 annual minimum without maintenance; $1200 with. Also, a month's vacation, two weeks' sick leave, and eight annual holidays, all with pay; seniority rights; and inclusion under the Social Security Act. None of these are covered in the A.F. of L. platform.

In addition, the C.I.O. has basic standards (which may vary according to local conditions) for members engaged in municipal hospitals or in private practice.

For the former it seeks: Civil Service status; minimum wages of $1,500 annually; a month's vacation while on general duty, or six weeks if assigned to operating-room, infectious, contagious, or radium services; health protection including periodic examinations and hospitalization; and a grievance committee for each hospital.

On behalf of private nurses, it is urging: An eight-hour day; $7 a day compensation, when meals are not provided, or $6 with two meals; Government supervision of registries; and seniority rights on the registry.

In struggling to obtain these ends, labor unions have discovered that nursing is not the same as industry. For one thing, the strike has proven entirely ineffective; in fact, it threatened to become a boomerang that would destroy the movement. After watching strikes of nurses in Omaha, Neb., Brooklyn, N.Y., and Comox, B.C., labor chieftains decided that walkouts on the

Breakfast with banners in Central Park, N.Y. celebrating two years of eight-hour duty for city-hospital nurses. Several hundred rose before dawn, to dine at 6:00 A.M., *go on duty at* 7:00.

*In the case of the C.I.O., for voluntary- and private-hospital staff nurses only.

Photos from N.Y. Daily News and International

When Mayor LaGuardia signed the eight-hour bill in 1937, he credited C.I.O.'s Luciel McGorkey (left). Ignored was the three-year educational program of the local A.N.A. office.

sick aroused no sympathy, but—quite the contrary—strong public resentment.

The C.I.O. Nurses' Union bans strikes and picketing, "as a policy, but not in principle." Thus, although strikes have not yet been called, the union reserves its right to this weapon.

So far, labor has aimed its drives at hospitals and their administrators, rather than at organized nursing.

It makes capital of the long hours, low pay, and unfavorable living conditions found in some institutions; using them to rouse "class consciousness" among nurses. Through organizers on hospital staffs, and the distribution of caustic circulars, it attempts to fan the flame of discontent wherever it is found.

Government institutions, especially, have been susceptible to this approach.

In New York City, for example, the C.I.O., led by Mary Luciel McGorkey, drafted and pushed through a bill making the eight-hour day compulsory in all city hospitals. It claims to have secured the reinstatement of nurses who had been fired; seen that seniority rights were enforced; eliminated fingerprinting of nurses in private hospitals; obtained better food for nurses; and established a central grievance committee in the Department of Hospitals.

All this activity has not been without the cooperation of city officials and local politicians. Why?

John L. Lewis himself gave the answer in a recent message to his nurses union's first convention. He reminded the delegates that "all members of the C.I.O. are behind you in your efforts."

That is perhaps the reason such independent mayors as Reading's (Pa.) J. Henry Stump and New York's Fiorello H. LaGuardia have hotfooted into the nurses' camps; that when Seattle hospitals and union nurses got into a squabble over wages, Mayor John F. Dore offered to represent the *nurses* on the arbitration board. Politicians suspect that while they might be able to afford to lose the votes of a few nurses, they cannot defy organized labor.

But private hospitals do not depend upon votes or politicians to any great extent. Their nurses and administrators have felt free to criticize the unions, and many of them have done so. Among the countercharges they have hurled at union membership are that:

1. It is comparatively expensive. While A.N.A. membership (district, State, and national) is available for $3 a year, union dues are $13 annually in the C.I.O., and $27.50 in the A.F. of L. (New York figures). Furthermore, unions customarily have extra charges which, while not compulsory, are practically so. The A.F. of L., for instance, sells insurance, which is described as one of its benefits.

2. It reduces nurses to the level of maids, porters, orderlies, janitors, and similar hospital workers. Since she is directly responsible for the patient, the nurse naturally bears the brunt of any unfortunate consequences of a labor dispute. But when the spoils of such warfare are divided, she often receives a comparatively small share. Following Seattle's union victory, for instance, hospital janitors were awarded monthly increases of $23, as compared to $10 for nurses.

3. It involves the nurse in labor problems entirely outside her profession.

4. It puts nursing problems up to laymen who are sometimes wholly unequipped to cope with them. The passage of New York City's eight-hour day law, without a thorough knowledge of its effects, is cited. After a year of that [*Continued on page* 28]

Left: Claire Rex and Margaret Burke were early union leaders. With fifty uniformed co-workers they stormed New York's Board of Estimate to urge better working conditions.

Right: The National Nurses' Association went to Albany to lobby against tightening-up of registration standards. Defeated, this group disbanded, reorganized under A.F. of L.

Hollywood Talks back

Has nursing been misrepresented in the movies? This exclusive story presents Hollywood's defense of its portrayal of nurses. Based on interviews with leading motion-picture executives, it is the second article in a series.

BY CHARLOTTE LUSCOMB

● Hollywood has a headache: Never before at one time have there been so many scripts on nursing subjects in production. Never before has the profession been so alert to the manner in which it is presented by motion pictures. Directors and producers, caught midway between these two poles, are working furiously to justify their position.

Most studios employ registered nurses as technical advisers. Most directors insist that neither they nor the producers want deliberately to misrepresent a profession. Yet the fact remains that nursing has had a poor break on the silver screen.

Intent on finding out whether or not Hollywood had anything to say in its own defense, I visited the leading studios—Paramount, Fox, Universal, Warner Brothers, RKO. I talked with representatives of the Motion Picture Producers and Distributors of America and with executives of the Will Hays office which rules on motion-picture standards. I interviewed nurse-advisers and actors.

The results of the investigation indicate that Hollywood has no conscious wish to distort the spirit of nursing. But, apparently, there are other considerations which the film moguls take into account.

At Warner Brothers, for instance, this argument was offered:

When a nurse goes to a motion picture that has a nursing theme, she sees a story about a *nurse*. When the lay public attends the same performance, it sees a *story*. In short, Hollywood's omnipotent god *is* the story. Motion-picture writers choose medical subjects because they afford dramatic material. While the medical profession is chiefly concerned with techniques, the public looks chiefly for drama.

"Any motion-picture director, whose pictures are to go over, has to bear this

"Cinema license" introduces comedy-relief after a tense delivery-room scene.

in mind," said Paul McWilliams, head medical-technical adviser at Warner's. "The story must come first, the human appeal take precedence."

At RKO, assistant director Syd Fogel agreed with Warner Brothers' opinion. "It is sometimes inevitable," he advised, "that strict realism must give way to drama. Not only the public, but nurses themselves would become bored if, for instance, we merely showed a nurse going through her daily routine. Drama must be introduced. If it conflicts with strict accuracy, accuracy may have to be modified. Sometimes the correct ethical procedure may seem queer to the layman. Thus, we claim 'cinema license' and set the scene or change the action to appeal to the masses of people rather than to the experts."

In the Will Hays office I was told that nurses are shown the way they are in pictures because "the public wants them portrayed that way." The public likes its nurses "young and beautiful." And, further, "Nurses are only interesting to movie-goers insofar as they are presented as human beings. All humans break rules and give way to certain weaknesses at times. Nurses are no exception."

Said one executive, "You can't win public sympathy for a monster of dutifulness. After all, we are not presenting The Nursing Profession. We are presenting an individual nurse, a human being, from that profession."

Tom S. Pettey summed up the attitude of the Motion Picture Producers and Distributors of America: "I think I can assure nurses that it is the desire of the motion-picture industry to present the character of the nurse in an honest, true, and pleasing manner." The Production Code, which controls good taste in motion pictures, according to Mr. Pettey, "reflects the sincere desire of producers to see that all roles depicting professions are true to life. Nursing is no exception. . ."

Thus, Hollywood justifies its stand on the grounds that it is "giving the public what it wants." If nurses detect a note of rationalization—an alibi—in this defense, it should not becloud the

Photos from "A Child is Born," Warner Bros.

The proud father must register emotion. So, off comes his mask in "A Child is Born."

Paul McWilliams has been Warner Brothers' medical expert for twenty years.

fact that Hollywood is apparently making a sincere effort to mend its ways from this point on.

Directors admit, for example, that they cannot entirely evade technical details for the sake of drama. If they did, recognized inaccuracies would forfeit the "willing suspension of unbelief" which must be the state of mind of the audience. Hence, technical experts are employed to effect a state of balance between story-drama and realism.

The life of the nurse-adviser in Hollywood is no sinecure. As one technical adviser remarked, a little wistfully: "The question that faces every nurse who is trying to advise on pictures is not, 'Is it likely to happen?' but 'Could it happen?' Well, there isn't much that couldn't happen and so your arguments often don't go far."

For "A Child is Born," to be released around Christmas, Warner Brothers called in nurses to instruct Gale Page, who plays the leading nurse role. She was taught how to handle instruments, what to touch and what not to touch, what to wear and how to wear it, how to conduct herself in the sickroom and in surgery. Great pains were taken with the operating room scenes so that every detail of costume, equipment, background and action might be accurate.

Given a perfect setting, however, a director's zeal for maintaining interest may lead him astray if he is not checked by the experts. Peggie Bell, nurse-adviser for Universal Pictures, tells a story about a new-born infant who wouldn't cry as required in the script. The director told the nurse to tickle the baby, hoping that the baby would cry and the audience laugh. Miss Bell wouldn't have it. She pointed out that such playfulness would be quite out of order in any delivery room. So the incident was not injected into the script.

During the filming of "Green Light," Warner Brothers engaged the services of Los Angeles General Hospital nurses.

"It's a boy!" Baby is the center of interest in this "behind-the-scenes" shot

"We took surgical nurses right out of the operating room," the medical director reported. "They were on the lot for two weeks, watching and advising. Sometimes, in a scene that requires technical skill we can get a waiver from the Screen Actors' Guild and let a surgical nurse (in mask and gown) double for the actress who is playing the part. Or, we will use the nurse's own hand for action 'hand inserts,' where instruments have to be handled with professional exactitude. That is how eager we are for strict accuracy."

Sometimes even the experts disagree as to the accepted procedure. One nursing school may teach one kind of surgical technique, another school something slightly different. Where the experts fail to agree, Hollywood believes it may justly claim some license and the director chooses what adds most to the story.

Dorothy Teeple, who was nurse-adviser for the Fox picture, "Wife, Doctor, and Nurse," reports an amusing incident. The director was so keen to have every detail exact that he paid a visit to The Cedars of Lebanon Hospital. There he observed surgeons scrubbing away, timing themselves by an hourglass.

Says Mrs. Teeple, "In my hospital we use a nice big clock. Hence, I included a clock in our Hollywood wash-up set. But the director had seen the hourglass and he loved it. So, we had both. The hourglass, I thought, was unnecessary."

If a star doesn't photograph well with a mask on in surgery, the director may insist that it be removed. Or, the mask may be taken off so that the audience may see emotion being registered. This departure from technical accuracy always disturbs nurse-advisers. But—they all agree—it is one of those instances of "cinema license" about which nothing can be done.

There is one other factor which influences nurse movies and which all nurse-advisers are eager to expose to other nurses: the cutting room. Here, apparently, occur many of Hollywood's "horrible mistakes." A nurse may see every rush that is made with a picture. But, if she can't see that picture after it leaves the cutting room, all her work may have been in vain. Cutters, who know nothing about the ethics of nursing, often snip out the very scene that would make the picture a success professionally.

All in all, it appears that Hollywood wants the support of the nursing profession. The whole essence of its message to nurses is: "If we've erred in the past, it's been the result of box-office pressure—not ignorance nor pigheadedness. For the future, we'll try to do a job that will win your approval, as well as the enthusiasm of the layman."

Toys for the convalescent child

BY FRANCES W. TAYLOR, R.N.

• "Now that Tommy is well enough to play a little, what toy would be best for him?"

If you were asked this question, could you answer it?

Here are a few ideas on inexpensive toys for convalescent children of preschool age:

For the year-old child, recommend building blocks. These come in soft rubber which can be washed. If the child throws them about, they will do no damage.

Many children as young as eighteen months can be kept happy and interested stringing beads. Because the baby will probably put the beads in his mouth, suggest large ones colored with vegetable dyes only.

For slightly older children, suggest some brightly colored wool, a blunt needle, and elbow macaroni which can be strung as a necklace.

Some two-year-olds enjoy construction toys. Those which consist of wooden spools and sticks are easy for the child to handle. Advise the child's mother, however, to find for him the unvarnished, smooth-wood variety which may be washed frequently. This type of toy is especially good when the child's freedom of movement is limited.

Books of push-out dolls, doll houses, Indians, automobiles, trains, cowboys, flowers, birds and trees will appeal to three-year-olds and children slightly older. These "push-outs" are more substantial than the average paper doll and, of course, eliminate the use of scissors (if the child is unable to handle these adequately.)

Quite young children like to make colored crepe-paper chains. The nurse or the child's mother can show him how to cut out narrow strips of paper and paste them [*Continued on page* 42]

"Is it true – "

By ROXANN

"Is it true that one nurse doesn't stay with the patient all the time?"

• Sometimes I think that nurses are the most misunderstood persons in the world. Not even Santa Claus has as many false conceptions growing up around him. How many times have I steeled myself for the blow when some one starts off a question about nursing with, "Is it true -----"!

I have, for instance, often heard of girls being in a situation where it became necessary to slap a gentleman's face. Smugly I've concluded that there must be some psychological drive—probably one with a Freudian basis—behind such uncivilized behavior. Until the other night. A newly met tall-dark-and-handsome and I were standing on the terrace of my favorite restaurant, talking. Suddenly he said, with the air of a scientist about to add one more fact to the sum-total of significant knowledge:

"Is it true that nurses have a lot more *personal* freedom than other girls? I mean, they *know* everything ----."

He was the thousand-and-oneth knight to make the insinuation. So I let 'im have it, right in his soulful left eye.

Of course, young men-about-town aren't the only ones who harbor erroneous ideas about nurses. Lots of other folks imagine we are a strange species not subject to the usual human tribulations and ills.

I'm thinking especially of the time I did private duty at the Van Briggans' summer home, nineteen miles from the nearest mailbox. The three Van Briggan kids found a sparkling stream. Drinking Indian style, they soon lapped up a supply of typhoid germs which were seeping down into the pretty brook from a neighboring farmer's ancient latrine.

Before a diagnosis could be established everyone in the household had become infected. When I arrived, papa and the cook had already taken to their beds. Mama was hysterical and the entire place was knee-deep in *Bacillus typhosus.*

I hadn't been inoculated against typhoid since my first year as a student nurse, and with a virtual field hospital on my hands it was a week before the job was done. It was too late for inoculation then, of course. I developed a headache and fever and, sure enough, the nurse had typhoid, too.

This catastrophe was too much for the Van Briggans. Their wails were heard as far as the local State Health Office. "Isn't she a graduate nurse?" they asked. And then, incredulously, "Is it true that nurses can catch diseases from their patients?"

Popular Misconception No. 3 is that nurses have no private lives; or if they have, they shouldn't. As for nurses hav-

ing regular and shorter hours, or time off for good behavior—tsk tsk, and don't be absurd.

Two of my young friends, Mary and Pauline, were doing staff duty last summer in a very busy hospital. The eight-hour day there was still only a wish. But everyone loved the superintendent and the work and somehow kept things running smoothly.

One night, Mary said, she and Pauline went for a walk. They were still in their rumpled uniforms and red-lined capes, and when a carful of youngsters their own age drove past in evening clothes

"When a carful of youngsters their own age drove past..."

they felt like twin Orphan Annies. To the South the lights blazed in the country club. Neither of the girls had ever had time to learn to hold a mashie, let alone play a round of golf. A placard in a store window advertised Alfred Lunt and Lynn Fontanne. But it had been months since Mary and Pauline had seen even a movie.

The two girls pledged themselves to fight for a few free hours each week. When the suggestion was brought up at the next board meeting, however, the president nearly had a cerebral hemorrhage. The other members swooned and had to be chauffeured home immediately.... A week or so later, when some of them began to recover, almost as one man they asked, "Is it true that nurses aren't satisfied just to *nurse*?"

Hospitals will remain a mystery to some people as long as they live, I'm afraid. For instance, the fond father whose 22-year-old pride and joy was laid low with appendicitis. He insisted on having a private nurse. "Night or day?" asked the clerk. Papa's brow looked like a ploughed field. "Night or day?" he echoed. "Why, uh—is it true that one nurse doesn't stay with the patient all the time?"

And is it true that nurses have to eat, especially night nurses? Perhaps one of the commonest difficulties of a night nurse on private duty is to persuade the family to leave a midnight snack for her. Most people have three meals a day. But the night nurse sleeps all day, awakens in the late afternoon, has breakfast, and goes on duty. Around midnight the Great Open Spaces begin to be felt down in the middle region. But it's a rare home where coffee and "victuals" are left out to take in the slack. If some of the peacefully sleeping relatives had to sit up all night in a cold house with a sick patient they'd feel differently. [*Continued on page* 48]

"He was the thousand-and-oneth to make the insinuation, so I let 'im have it."

"... with boots on"

• How many days' pay did you lose this year due to illness? How many days did you drag yourself on duty when you felt miserable enough to trade places with your patient?

Because nursing is rich with the tradition of service, nurses have learned to sublimate personal-health interest into patient-health interest. Hospitals, nursing associations, and placement bureaus have permitted this condition to flourish. Not, of course, by encouraging *sick* nurses to minimize their illness; but by tneir attitudes toward *well* nurses.

Perhaps some of you may recognize these administrative comments: "But, eight more patients on the ward shouldn't bother you." . . . "The trouble with the private-duty section is they are all too concerned about themselves and not enough about nursing." . . . "Well, even if you *have* been on twelve-hour duty for the past six months. Isn't that better than no case at all?" "You're just being stubborn. There's no reason in the world why you shouldn't live in our nice new nurses' residence!"

We don't need a magician to demonstrate that long hours, heavy patient-load, poor food, inadequate recreation, insufficient rest all help make Nell a dull girl—and often a sick

one. Nor do we need statistics to dramatize the fact that far too many nurses become ill, or wear themselves into old-age while they are still comparatively young women.

Common colds, pneumonia, tuberculosis, and nervous breakdowns—these are the ailments which we most frequently develop. Since we know this to be the case, why are we not developing long-range health programs through our professional organizations? Why have we not under way concrete—not theoretical—plans for improving living and working conditions for *all* nurses?

Let us not, however, place the entire responsibility in the hands of our employers or our nursing associations. Each of us has an *individual* responsibility: First, we should insist upon having a thorough physical check-up at least once a year. If the hospital does not provide this, we must seek it from a private physician. Second, we can refuse to play the martyr, forget that we ever heard it was noble to "go down with your boots on." Nothing is gained by pretending "Why, *I'm* perfectly all right" until you're flat on your back and, perhaps, beyond medical aid.

Service need not imply self-sacrifice. If the patient's health comes first, let us at least see that the nurse's health runs a close second. For 1940, let us make " . . . with boots on" the slogan not for defeat by illness but for more days on duty due to better health.

Salesman for

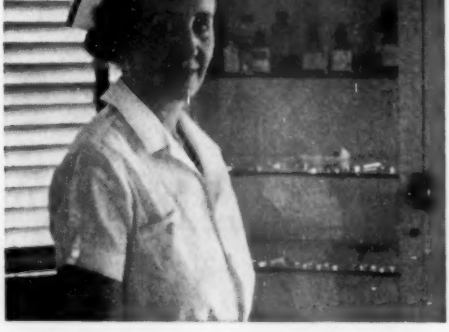
No two nursing posts are alike. Believing that readers want to know more about what other nurses are doing, R.N. *begins this month a new feature on nurses in interesting fields.*

BY MONA HULL, R.N.

• Mike O'Halloran comes into the first-aid room of the factory, with a bad gash on his right forefinger. "How did you do it, Mike?" asks Miss Olbert, busy with dressings and adhesive. "Anything wrong with that cutting machine? What can we do so that this doesn't happen next time?"

It's *next time* that worries Mildred Olbert, industrial nurse for Westinghouse Electric Elevator Company. Accidents *do* happen occasionally and when they do she is ready to go into action. But her first concern is to safeguard factory workers, and to teach them to safeguard themselves. "An industrial nurse must sell safety every minute that she is on the job," she says.

"But how?" we ask, looking over the extensive buildings and equipment.



Mildred Olbert's formula is simple: "Make friends with the whole factory!"

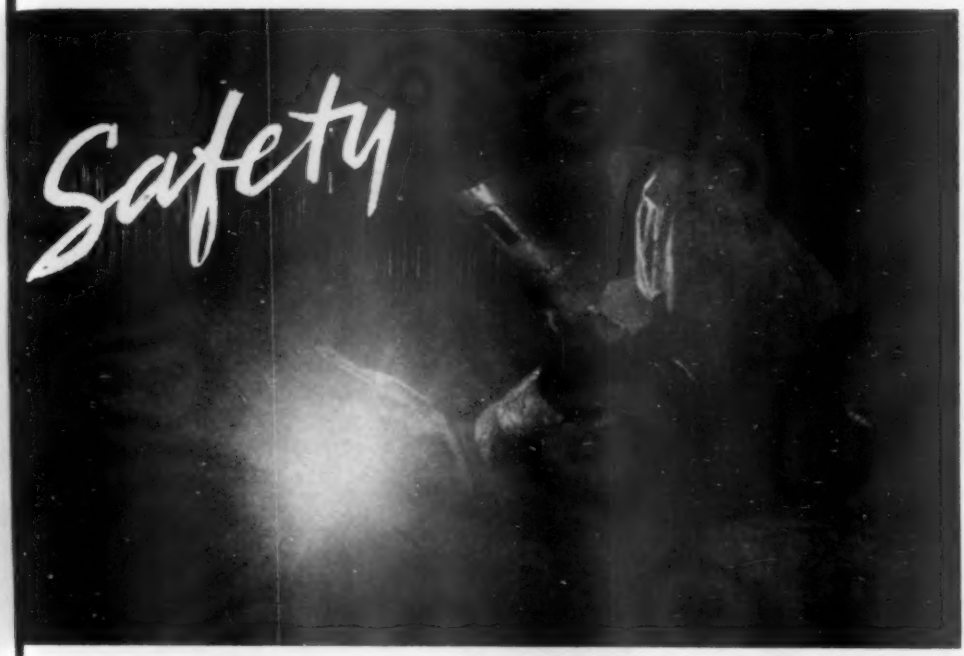
"How *can* you sell safety to so many people, in so many different jobs?"

Miss Olbert laughs. "It looks harder than it is," she says. "You just have to make friends with the whole factory."

To the visitor who calls on her at the Westinghouse plant in Jersey City, (N.J.), it's obvious that Miss Olbert has done just this. She is a personal friend of each one of the 500 workers, calls Mike and Joe and Roy by name when they come to see her. She "puts over" her safety ideas in an informal atmosphere, not as an official program, but as part of her everyday contacts.

"Every man should know his own machine and its hazards," Miss Olbert says. "When he has an accident, it's up to me to try and help him figure out why it occurred. And, of course, how to prevent it from happening again!"

Like many large industrial plants, Westinghouse is a place where serious accidents *could* occur if workers and executives ever relaxed precautions. Here are manufactured the huge ele-



vators which transport passengers to the 65th floor of New York's Rockefeller Center in 37 seconds. Here also were built escalators for the World's Fair, and the massive steel base for the "carry-go-round" used in the General Motors exhibit.

In the structural steel department of the plant, workers manipulate huge steel girders. Cranes move back and forth over their heads. Welders put heavy framework together; huge cutting machines chop off steel blocks. Bad accidents could develop if workers were careless.

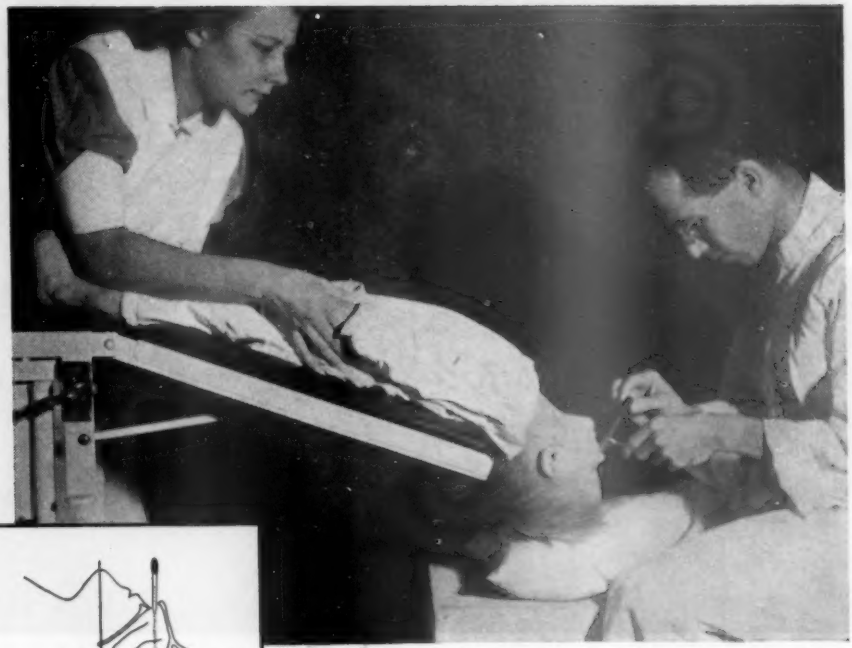
And yet, the factory's safety record is something to be proud of—only fifteen working days were lost due to accidents during the past year. This isn't just chance, but the result of a planned safety program, mapped out by officials, with the aid of the nurse.

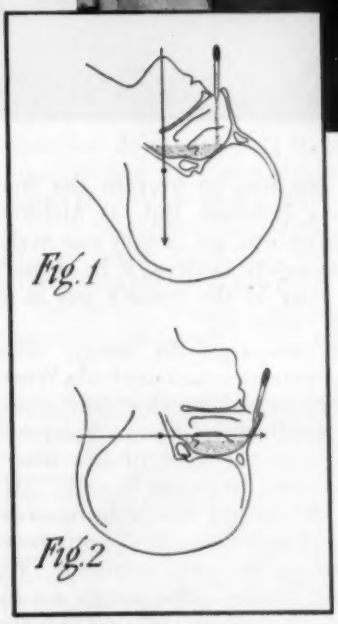
For dangerous work, safety devices are provided. Welders have steel masks and heavy gloves. Structural steel workers wear special shoes, with metal supports in the toe, to prevent the foot from being crushed. But, as Mildred Olbert points out, no factory can *make* a man use safety devices, if he doesn't want to. Part of the nurse's job is to make him "want to!"

In her campaign for safety, Miss Olbert has some original methods. When accidents do occur, she charts the number on a cardboard "dummy worker," who hangs on the wall of her office, and whom she affectionately calls "Mr. Chase." "Mr. Chase" shows dramatically which parts of the body are most often hurt in factory accidents. He proves, for instance, that hands are by far the most vulnerable part of the worker's body.

"Mr. Chase" goes to the monthly safety meetings, too. Plant officials are particularly proud of him. Miss Olbert thinks he might be adapted for the use of other industrial nurses, so that every factory would have its Mr. Chase, just as every hospital has its Mrs. Chase.

When the [*Continued on page* 34]





Courtesy J.A.M.A

Administration of zinc sulfate in polio prophylaxis requires skill. Note incorrect position of head in Fig. 1. In the correct position, Fig. 2, the solution reaches the site where the virus is thought to enter the olfactory nerves.

Quick facts about

Poliomyelitis

• The position of poliomyelitis in the realm of medicine is unique. Despite intensive research by highly qualified investigators, little is known of this dread condition which leaves in its wake many paralyzed and deformed victims.

Acute poliomyelitis.—Acute poliomyelitis is apparently an acute infectious disease. It specifically attacks the anterior-horn cells of the spinal cord whence emerge the motor nerves. The condition seems to be due to a filtrable virus, a virulent micro-organism estimated to be one-hundredth of a micron in diameter and therefore invisible. Other bacteria have been thought

responsible, including a streptococcus isolated by Rosenau.

The mode of transmission is not established. The disease is not highly contagious or infectious; more than one patient in a household is rare. Human carriers, contaminated milk and water supplies, and animals and insects have all been suggested as transmitters, although adequate proof is lacking. Some mechanism of transmission must operate, however, since outbreaks epidemic in character do occur in localized areas and communities.

Research workers disagree as to how the invading micro-organism gains foothold in the human body. In experimental animals, poliomyelitis is produced most easily by injecting the virus into a nervous structure—the brain, sciatic nerve, or the eye. Because the olfactory nerve-endings, located in the upper portion of the nose, are the most easily accessible human nerves, some authorities believe the virus enters through these fibers. This theory presupposes inhalation of infected mucus droplets as the transmitting factor. Since poliomyelitis has been produced in the laboratory by feeding contaminated food, still another theory holds that the virus travels via the sympathetic nerves of the intestinal tract to the spinal cord. Most investigators agree, however, that the micro-organism reaches the central nervous system by way of some nerve pathway and not via the blood stream.

Like influenza, poliomyelitis appears in waves. Its peak is in August and September, although sporadic cases do occur throughout the year. Both sexes are afflicted equally. The most susceptible ages are five to ten years, hence poliomyelitis is primarily a children's disease. However, all age groups are attacked. Economic status does not play a significant role. Incidence is greatest among the rural population.

Relatively speaking, poliomyelitis is not deadly. The mortality rate ranges from 5 to 15 per cent, death occurring from bulbar paralysis, respiratory paralysis, or terminal bronchopneumonia.

Clinical course.—The incubation period is without symptoms and is thought to be from three to fifteen days. The actual onset is acute. The temperature rises to 101° to 104°. Drowsiness, lethargy, restlessness, and loss of appetite quickly develop. The patient appears more seriously ill than would be expected from the elevation in temperature. Headache, severe pain in the neck, rigidity of the neck, and muscular tenderness are especially significant. On the second or third day of this acute period, paralytic involvement of various muscle groups occurs. The location and extent of muscular involvement is unpredictable. It is not related to the severity of the infection. When paralysis appears, the temperature drops and the acute stage subsides.

Not every case of poliomyelitis leads to paralysis. One form, for instance, presents all the symptoms—including spinal fluid changes—but does not progress to the paralytic stage. In the paralytic variety, there are two major forms.

The most common involvement is that of the nerves emerging from the spinal cord. Any muscle group of the limbs or trunk may be paralyzed. If the intercostal muscles, the diaphragm, or both become involved, breathing is difficult. Artificial means of respiration are needed to keep the patient alive.

In the bulbar form, the ninth and tenth cranial nerves are involved (the glossopharyngeal and vagus), leading to difficulty in swallowing.

The initial degree of muscular paralysis always decreases. Improvement may be manifest for many months or years. But in severe involvement, atrophy of the muscles takes place, producing not only permanent paralysis but deformity as well.

Laboratory findings.—Elevation in the leukocyte count reveals the pres-

ence of infection. Values of from 10,000 to 15,000 are the rule.

In doubtful cases, or during the preparalytic stage, the spinal fluid changes are of utmost significance. The fluid is found to be under pressure. It is turbid and at times cloudy. Albumin and globulin content increases, and the number of cells is multiplied to as much as 1,000 per cubic millimeter. These findings are rather constant.

Prophylaxis.—Many ingenious attempts have been made to protect susceptible subjects from the ravages of poliomyelitis. On the whole, these have failed.

Poliomyelitis virus is found in large numbers in spinal cord tissue. By emulsifying the cords of affected animals, vaccine can be prepared. There are two major types of vaccines—one in which the virus is destroyed, the other containing the virus attenuated in virulence. Neither has produced convincing results, and the latter is thought to be potentially dangerous.

Convalescent human serum, obtained from patients who have recovered from the disease, was tried but practically abandoned because it neither prevented nor arrested the disease.

In recent years, the use of nasal sprays has become increasingly popular. It is assumed that sealing the portal of entry (the olfactory nerve endings) by sclerosing agents should afford protection.

Alum, picric acid, and zinc sulfate solutions have been used for this purpose. The solution, instilled with delicate technique, flows over the mucous membrane of the nose on which the olfactory nerves terminate. The nerve endings are partially destroyed and "sealed," forming a protective barrier against the virus.

The value of this method is not yet established. Obviously, its effectiveness depends on the truth of the theory that the virus gains [*Continued on page* 36]

"ANCOA" nurses have wings!

Official nursing organization for the National Aeronautic Association, the Aerial Nurse Corps of America is our oldest aviation-emergency group. With branches throughout the country, ANCOA trains "physically qualified and technically trained registered nurses for duty in air ambulances, flying hospitals, at air bases, and in air transports." Here (see cut) *five members transfer an acutely ill patient from ambulance to plane. . .Corps headquarters are in Burbank, Calif.*

Nutrition *Briefs*

● "We serve no fried foods," has long been the boast of many a camp, school, and hospital head. Now, at the University of Wisconsin, studies on the vitamin content of meats and meat products suggest that this attitude is ill-advised.

Meats, it was discovered, besides being good sources of proteins and fats, are above the average in Vitamin B_1 content, comparing favorably with many foods which are ordinarily considered potent sources of this vitamin. The average is 0.5 to 2.0 I.U. of the vitamin per gram. Ordinary muscle cuts of beef and lamb were found to contain 2.0 or more I.U. per gram. Pork muscle contains approximately the same amount as does baker's yeast, which has always been looked upon as one of the richest sources of the antineuritic vitamin.

Experiments were then made to determine the destruction of this vitamin effected by the ordinary household cooking methods. Surprisingly enough, it appeared that frying produced the least change. Vitamin B_1 content was preserved *almost complete* in fried beef round and pork ham. There was a 30 per cent loss in the case of pork loin and 45 per cent in veal chops. But roasting, broiling, baking, and stewing produced a destruction of the vitamin approaching 50 per cent to 60 per cent. Vitamin B_1 is apparently very sensitive to heat, especially in the presence of moisture; hence, the greater decrease in vitamin content produced by these methods of preparation.

Thus the lowly fried pork chop comes into its own. No longer is it to be looked upon as merely a synonym for indigestion, but accorded a prominent place in the diet, as a source of the vital antineuritic vitamin. *Mickelsen, Waisman, and Elvehjem: Vitamin Content of Meats and Meat Products. Jour. Amer. Dietet. Assoc., August-September* 1939.

● It's long been a popular notion that to get *any* Vitamin C out of your morning glass of orange juice, the orange must be

cut, squeezed, and the juice downed in as short a time as possible. Recent tests show, however, that you won't lose much Vitamin C, and you may gain another forty winks in the morning, if you squeeze your orange juice at bedtime and put it in the refrigerator.

Juice was prepared and poured into stoppered flasks. Half was placed in a refrigerator; the other half, allowed to stand at room temperature. Ten, hourly tests were made to determine the Vitamin C content.

Oddly enough, during the first few hours, Vitamin C content was apparently higher—due, possibly, to its initial liberation activity. Even after 24 hours, the refrigerator sample showed 97.6 per cent of the Vitamin C content still present. The sample standing at room temperature showed slightly less. If the juice had had more access to air, there might, however, have been a greater loss.

Junior may need that extra 2.4 per cent vitamin content that seems to slip away during the night. But for ourselves—we'll set the alarm five minutes later!—*Loss of Vitamin C in Orange Juice on Standing. Jour. A.M.A., June* 1939.

In UNIONS

[*Continued from page* 13]

law, the city's hospitals commissioner, Dr. S. S. Goldwater, reported that its effect upon nursing standards had been so pronounced that an intensive educational program had to be launched. He added that "anticipated effects on the health of graduate nurses have not been realized; illnesses and absences have decidedly increased."

5. It destroys necessary discipline by negating the power of nurses in executive positions.

6. Inasmuch as union leaders have not renounced strikes "in principle" the door is open to walkouts, with possible disastrous effects upon patients.

7. Needed reforms should be pressed through the educational machinery of organized nursing, rather than by the militant tactics of trade unions.

It must not be inferred, however, that *all* private voluntary hospitals are hostile to trade unions. On the contrary, there have been some conspicuous instances of hospitals espousing their cause. In 1937, Brooklyn's (N.Y.) Crown Heights Hospital signed a union contract covering its nursing staff. It set a $60-a-month minimum, and a 5 per cent raise for nurses who had previously earned over this amount; guaranteed a "closed shop" (employment of union nurses only); and called for arbitration of disputes. Since last July, New York City's Beth Israel Hospital

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HOW UNION DEMANDS COMPARE
WITH ORGANIZED NURSING'S RECOMMENDATIONS
(For staff nurses in voluntary and private hospitals)

C.I.O.	*A.F. of L.*	*Calif. State Nurses' Ass'n.*
Consecutive eight-hour day	Consecutive eight-hour day	Consecutive eight-hour day so far as possible
Collective bargaining	Collective bargaining	Individual contracts
$100 a month minimum salary with maintenance for general duty; $125 without maintenance	A "living wage" with overtime in emergencies	$80 a month minimum salary with maintenance, for general duty; $95, with three meals and laundry; $125 without maintenance
Nourishing foods; clean and light living and dining quarters	Improved living conditions; clean, attractive private quarters; wholesome appetizing meals, mealtime included in hours of duty	Salaries sufficient to enable nurses to choose their own manner of living; cash equivalent of monthly maintenance being $45 to $50
Month vacation with pay	——	Two weeks vacation with pay
Two weeks' sick time with pay	——	One week sick time with pay
Eight annual holidays with pay	——	Maintenance of days off as posted, except in emergency
Seniority rights	——	——
Inclusion under the Social Security Act.	——	——

Comparative Tests for FREE Salicylic Acid in Gastric Content After Ingestion of Aspirin or Alka-Seltzer . . .

CROSS-SECTION TABULATION
OF EXPERIMENTAL RESULTS

SUBJECT	TIME OF COLLECTION OF SPECIMENS MINUTES	QUALITATIVE TESTS FOR FREE SALICYLIC ACID IN GASTRIC CONTENTS	
		AFTER GRUEL MEAL AND ASPIRIN	AFTER GRUEL MEAL AND ALKA-SELTZER
T. C.	15	+++	0
	30	++++	0
	45	+++	0
	60	++	0
	75	+	0
	90	±	
	105	0	
	120	0	
M. C.	15	++	0
	30	+++	0
	45	++	0
	60	+	0
	75	±	
	90	−	
	105	0	
E. B.	15	+++	0
	30	++++	0
	45	+++	0
	60	−	
	75	−	

THIS investigation was undertaken as part of a comprehensive study to determine the value of Alka-Seltzer as an agent for the relief of certain minor ailments.

One of the many laboratory and clinical experiments undertaken is summarized herewith.

Full details of this and other informative studies are being compiled in the form of an illustrated brochure which will be sent to interested physicians on request.

CONCLUSIONS

1. All qualitative tests for free salicylic acid (or acetylsalicylic acid) were negative in specimens of gastric contents aspirated at intervals of 15 minutes after the ingestion of Alka-Seltzer with the gruel meal until the stomach had been emptied completely.

2. All specimens of gastric contents analyzed for periods ranging from 45 to 75 minutes after consumption of aspirin with the meal gave positive tests for free salicylic acid (or acetylsalicylic acid) varying in intensity from + to ++++ reactions.

The absence of free salicylic acid in the gastric content following ingestion of Alka-Seltzer is clinically significant. It suggests a lessened tendency toward possible irritant action of the analgesic on the gastric mucosa.

MILES LABORATORIES, INC.
OFFICES AND LABORATORIES: ELKHART, INDIANA

has also included nurses in its union contract.

Similarly, the Catholic Hospital Association has gone on record as accepting unionism. In a resolution, passed at its annual convention, it affirmed its "full acceptance of the principles, in conformity with the teachings of His Holiness Leo XIII and His Holiness Pius XI, that employees, including those in our institutions, have the right to unionization."

But these are the exceptions rather than the rule. The boards of most private hospitals strongly oppose unions.

At this writing, the unions are searching for a way to bring private hospitals into line. One possibility, suggested by a New York City Council resolution, is that public funds be withheld from private or voluntary hospitals that refuse to bargain collectively. Another is the passage of State legislation that would force the union demands upon all institutions, public and private.

Union heads have tried to maintain peaceful relations, at least outwardly, with organized nursing. On the other side of the fence, however, leaders are well aware that the lion and the lamb will never lie down together. Hence, the American Nurses' Association's policy that it "does not . . . recommend nurse membership in unions."

Recent events in two States confirm the opinion that unions and nursing associations will never agree.

In New York, the clashes between the two groups have been severe. The State nurses' association and the union have been at opposite ends of a tug-of-war on practically all the important legislation affecting nursing during the past two years. In convention, this Fall, the N.Y.S.N.A. passed a resolution disapproving membership in unions for registered nurses as being "inconsistent with the ideal of service for which organized nursing stands."

In California, the State nurses' association has stolen much of the unions' thunder by waging its own campaign for better nursing conditions. Drawing up the recommendations listed under its name in the table that accompanies this article, it presented them to the California Hospital Association for consideration; tested them in its placement service; and urged its members to use them as a basis for individual contracts with hospitals. This activity is believed at least partially responsible for a wave of pay raises which, soon after the recommendations' appearance, struck Oakland hospitals.

Whether such programs will force the unions into obscurity or whether they will continue in a triumphant rise, are questions that only time can answer.

Meanwhile, the average nurse is grateful to unions for at least one thing: the increasing attention they are focussing upon the improvement of her working conditions.

3 NURSES TALK ABOUT AN INTIMATE SUBJECT

Like many a nurse, I'm on my feet long hours every day—even "difficult days." So I'm grateful for "Moisture Zoning." Thanks to this new feature, the edges of a Modess pad stay dry and soft longer than ever before. Result—less chafing.

I'm in the public eye—in a white costume—eight hours a day. So you bet I'm glad of Modess' "Moisture Zoning," which means greater absorbency. And this—with Modess' moisture-resistant backing—gives me less fear of accidents, greater peace of mind.

I believe that comfort makes a nurse more efficient. That's why I've always liked Modess for its downy-soft, fluff-type filler—entirely different from layer-type napkins! Modess not only starts softer, it *stays* softer!

FREE to Nurses:

Two authoritative booklets on Menstrual Hygiene . . . For younger girls, "What a Trained Nurse Wrote to Her Young Sister." For older girls, and every woman, "The Periodic Cycle." Write for as many booklets as you need. Address: Personal Products Corporation, Dept. 22, 500 Fifth Avenue, New York, N. Y.

Calling all nurses

Is there someone in the profession you'd like to locate? You may insert here, without charge, a 75-word notice. Items will be published in the order received. Be sure to include your full name and address so that replies may reach you. Just address the "Calling all nurses" editor.

WEST SUBURBAN GRADUATES: Oak Park, Ill. Class of 1934. It has been so long since I have seen or heard from any of you. Please write if you read this. Tillie Bauman, 732 South 16th St., St. Joseph, Mo.

WESTBORO STATE HOSPITAL ALUMNAE: We are anxious to correct our mailing list, and would also like to hear from each and every one of you. Why not write today? Tell us what you are doing, where you are, and how you are. All communications may be addressed to: Theresa L. Murphy, Secretary of the Westboro State Hospital Alumnae Assoc., Box 288, Westboro, Mass.

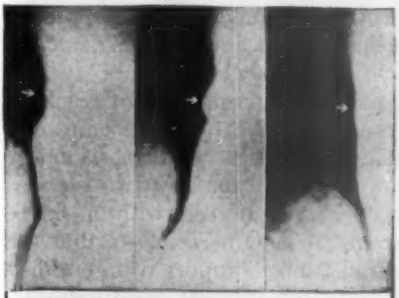
IRENE McNEILL: Your Dixon State Hospital nurses' pin was found in Chicago some months ago. You may have it by writing me at this address: John F. Quinn, R.N., 1049 N. LeClaire Avenue, Chicago, Illinois.

ALL NURSES: My hobby is collecting postcards from different States and foreign countries. I'd like to hear from nurses everywhere. Won't you send me a postcard? Evelyne Page, Limestone College, Gaffney, S. C.

ANNA AND BERNICE BRIDGES: You still have an old friend who thinks of you very often. I would love to hear from both

Prompt Symptomatic Relief in PEPTIC ULCER

. . . with PLAIN KNOX GELATINE (U. S. P.)



CASE I—FEMALE, 74

Uncomplicated gastric ulcer first demonstrated by Roentgen rays in 1934. Diet and alkalies afforded little relief. Accompanied by loss of weight. Repeated X-ray studies in 1936 and 1937 showed no improvement. She was placed on a diet-gelatine regime in November, 1937. Relief immediate. Gained weight. Roentgen studies in April, 1938 showed no demonstrable ulcer.

CLINICAL research has recently demonstrated the effectiveness of utilizing plain Knox Gelatine (U.S.P.) in treatment of peptic ulcer. In a group of 40 patients studied, 36 (or 90%) were symptomatically improved; 28 of these (or 70%) experienced *immediate relief of all symptoms.* Other than dietary regulation which included frequent feedings of plain Knox Gelatine no medication was given except an occasional cathartic.

NO DANGER OF ALKALOSIS

This regime thus eliminates the "alkalosis hazard" attendant upon continued alkali therapy. In discussing the mode of action by which gelatine brings peptic ulcer relief, Windwer and Matzner* speak of the acid-binding properties by which proteins can neutralize acids, and they state that the frequent gelatine feedings "apparently caused more prolonged neutralization of the gastric juice."

PEPTIC ULCER FORMULA

Empty one envelope Knox Gelatine in a glass three-quarters filled with cold water or milk. Let the liquid absorb the gelatine. Then stir briskly and drink immediately before it thickens. Take hourly between feedings for seven doses a day.

*Windwer and Matzner, *Am. Jl. Dig. Dis.* 5:743, 1939.

NOTE: The gelatine used in this study was plain Knox Gelatine (U.S.P.) which assays 85% protein and which should not be confused either with inferior grades of gelatine or with sugar-laden dessert powders, for these latter products will not achieve the desired effects. When you desire pure U.S.P. Gelatine, be sure to specify KNOX. Your hospital can get it on order.

WRITE DEPT. 450

KNOX GELATINE LABORATORIES
JOHNSTOWN NEW YORK

Please send complete details of the Knox Gelatine peptic ulcer regime.

*Name*_____

*Address*_____

*City*_____ *State*_____

of you. The last I heard was that Anna was on the teaching staff of a Boise (Idaho) hospital. Bernice trained and graduated from a hospital in Salt Lake City (Utah) around 1927. I would appreciate hearing from either, or from anyone knowing where the Bridges nurses are. (Mrs.) V. H. McCabe, E. 328 Mission Ave., Spokane, Wash.

Salesman for safety

[*Continued from page* 34]

Westinghouse nurse needs ideas for safety meetings, she writes to the National Safety Council for speakers and program suggestions. Then the council also provides bright red and blue safety posters for display on factory bulletin boards. The New Jersey Department of Labor runs a State-wide contest each year, in which factories compete for safety records. Any industrial nurse can receive a good deal of help from the Safety Council, if she wants to ask for it.

Mildred Olbert believes there is more to "this safety business" than prevention of accidents. Plant workers should be better informed on how to take care of themselves and their families. "When a man comes into the nurse's office," she says, "he should get some information about health and general hygiene. For instance, a bright, attractively furnished treatment room helps teach cleanliness, good housekeeping, and the prevention of infection."

Apparently this method of teaching has "sunk in." Not a single employee has had an infection resulting from any factory injury, in the past two years.

In order to succeed with a safety program, Miss Olbert insists that the nurse must have support from enthusiastic plant officials. At Westinghouse, O. W. Lindstrom, industrial manager of the factory, is just as concerned about

MANY A DOCTOR SAYS that nothing takes the place of cod liver oil in helping children develop sturdy frames and sound teeth.

YET, AS A NURSE, you've experienced difficulty in getting children to take cod liver oil. Many of them dislike its taste. It makes others regurgitate. If you have such patients, recommend the **BETTER—MORE PALATABLE—WAY TO TAKE COD LIVER OIL . . . SCOTT'S EMULSION!**

1—Scott's Emulsion has *all* the values of cod liver oil and is four times more easily digested.

2—Easily Digested—The exclusive method of emulsifying the oil permits digestion to start in the stomach, whereas digestion of plain cod liver oil does not begin until the oil passes into the intestines.

3—Easy to take—Scott's Emulsion has a pleasant taste. Easy to take and retain by children and adults.

4—Economical—Scott's Emulsion is an economical way to obtain the Vitamins A and D so necessary to strong bones and sound teeth.

SCOTT'S EMULSION

safety as the nurse. Plant executives give their whole-hearted support to preventive aspects of the nurse's work. If Roy Larsen has a bad cold, and a slight fever, they agree that he should be sent home—not only to prevent more serious sickness but to protect the rest of the plant from a "sneezer."

Plant officials realize how important it is for the nurse to know each worker intimately. Hence, they have appointed Miss Olbert personnel manager. She is the first person who meets the worker when he comes to apply for a job. In this first short interview, she learns many facts about the man and his family. She checks on his job references, and qualifications. If the man is hired, she makes arrangements for his physical examination and chest X-ray.

Men can come "to see the nurse" any time during the day. Even lunch hour is not inviolate: the nurse "eats in" so that she can be on hand should anyone need her. Minor injuries are treated on the spot; major ones are sent to the nearest hospital by ambulance, and cared for by company-paid doctors. All injuries are recorded in a special file for future reference.

Miss Olbert does a rushing business in "foreign-bodies," cuts, and bruises. She is an authority on first-aid in emergencies. But the part of her job which she loves best is safety education. The Westinghouse safety record indicates that her efforts are being well spent.

Poliomyelitis

[*Continued from page* 26]

access exclusively through the olfactory nerves. Its drawbacks are the involved technique and the fact that many subjects temporarily lose their sense of smell. Such prophylactic instillation is made about twice monthly during epidemic periods.

Serums have been prepared by inoculating experimental animals with

organisms thought to be responsible for poliomyelitis. Both the virus and the streptococcus have been used to obtain antiserums. As with the convalescent serum, conclusive results have not been obtained.

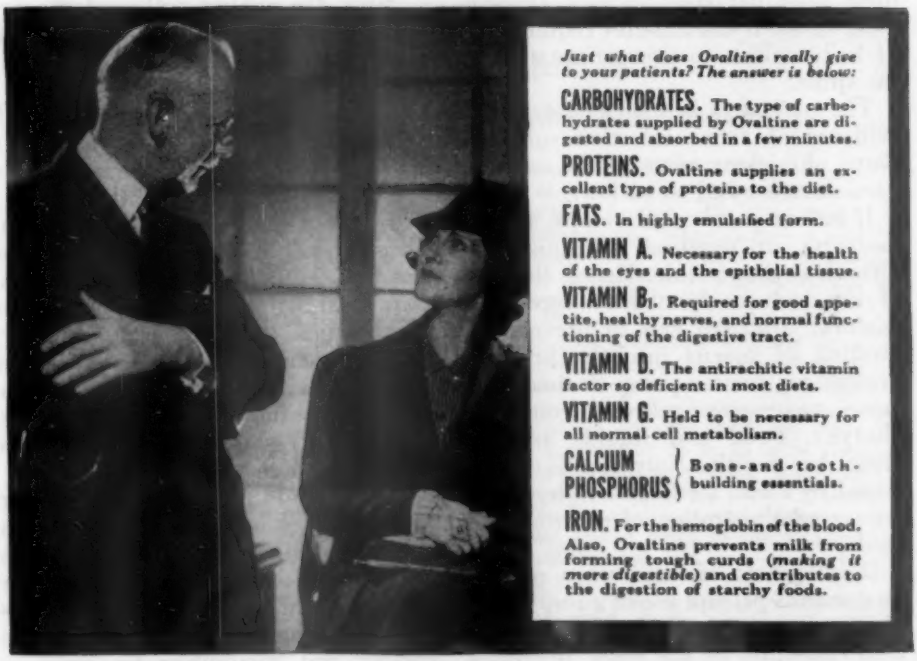
Treatment and nursing care.—Unfortunately, there is not as yet a specific or curative measure in poliomyelitis. Treatment, therefore, is largely supportive. It aims to prevent deformity in the involved extremities. The burden of this care falls largely to the nurse.

The patient with acute poliomyelitis must have absolute bed rest. Isolation technique is used, and all nasal and intestinal excretions are disinfected with chlorinated lime.

During the febrile stage, the patient is fed a high-caloric diet. For the first four days, when paralysis may occur, the patient must be watched constantly and carefully. The first indication of bulbar or respiratory paralysis must be immediately detected and reported to the physician. Changes in the rate and depth of breathing and development of cyanosis signify impending respiratory paralysis. Difficulty in swallowing and regurgitation of food out of the nose indicate bulbar paralysis. The development of either complication calls for prompt therapy.

Muscular paralysis develops in about half of the patients. In many cases it is preceded by tenderness and pain in the involved parts. An elaborate series of tests enables the physician to determine which muscles are partially or completely affected.

With the advent of paralysis, the affected limb is placed in a padded splint to prevent deformities. When a flexor muscle is involved, the extensor group tends to pull the part into a position of extension. If this is not prevented, the paralyzed flexor, which undergoes atrophy, stretches permanently. Considerable difficulty may develop unless corrective measures are insti-



Just what does Ovaltine really give to your patients? The answer is below:

CARBOHYDRATES. The type of carbohydrates supplied by Ovaltine are digested and absorbed in a few minutes.

PROTEINS. Ovaltine supplies an excellent type of proteins to the diet.

FATS. In highly emulsified form.

VITAMIN A. Necessary for the health of the eyes and the epithelial tissue.

VITAMIN B_1. Required for good appetite, healthy nerves, and normal functioning of the digestive tract.

VITAMIN D. The antirachitic vitamin factor so deficient in most diets.

VITAMIN G. Held to be necessary for all normal cell metabolism.

CALCIUM, PHOSPHORUS } Bone-and-tooth-building essentials.

IRON. For the hemoglobin of the blood. Also, Ovaltine prevents milk from forming tough curds (*making it more digestible*) and contributes to the digestion of starchy foods.

What can this "PROTECTING FOOD" REGIMEN do for your patients?

WHEN the problem is to "build up" a patient, Ovaltine can have an important place in your dietary recommendations.

The reason is that Ovaltine supplies such a wide variety of important food elements and properties.

It contributes quickly-absorbable carbohydrates, proteins of highest quality, fats in emulsified form, four essential vitamins (A, B_1, D and G)—in addition to calcium, phosphorus and iron. Besides this, it aids in the digestion of starchy foods and makes milk more digestible by its capacity to reduce the tension of the milk curd.

And—Ovaltine is extremely easy to digest.

Hence it is in a real sense a "protecting" food-drink, suitable for (1) anorectic children who are underweight and nervous, (2) convalescents, (3) elderly people, (4) expectant and nursing mothers and (5) those who cannot drink tea or coffee or who suffer from a depletion of their energy between meals. *The building and "protecting" properties of Ovaltine fit it ideally for inclusion in the dietary of all these classes of patients.*

Ovaltine is not a "vitamin and mineral concentrate." It is a homogeneous, well-rounded dietary supplement designed to fill "gaps" in the diet.

Why not advise it more often? It is available everywhere; easy to prepare, and makes a delicious drink that your patients will enjoy.

Ovaltine

(RICH IN "PROTECTIVE" FOOD FACTORS)

tuted when paralysis appears. Involvement of the trunk muscles requires use of body splints to prevent rotation of the spine.

The patient is kept in bed until all evidence of active infection subsides. Some physicians advocate the use of a hard mattress and no pillow.

If bulbar paralysis develops, special measures are required. Swallowing is difficult or impossible. Hence, the foot of the bed is elevated to encourage postural drainage and to prevent aspiration of mucus into the bronchi. Continuous suction-pump drainage removes excessive mucus from the pharynx. Food and liquids are not given by mouth. Nutrition is maintained by rectal feedings and by intravenous administration of dextrose and fluids.

Development of respiratory paralysis demands prompt use of a respirator. This apparatus encases the patient, with exception of the head. It creates an intermittent negative pressure about the body, causing air to flow from the outside into the lungs. The rate of "breathing" can be regulated. Constant, intelligent nursing is required, since the patient cannot take care of any of his needs. He should never be left alone while in the respirator. Talking is discouraged. Swallowing is permitted only during expiration or during the intervals between inspiration and expiration. Modern machines contain many windows which permit catheterization, the use of bed pans, etc.

Since the rubber collar of the respirator irritates the skin of the neck, daily washing with alcohol and application of talc are needed.

An emergency tray containing sterile syringe, stimulants, tongue clamp, airway, and tongue depressor should be beside the patient constantly.

The respirator is not the life-saving measure popularly supposed. It cannot be used in the presence of bulbar paralysis. Its prolonged use leads to emphysema and other pulmonary changes which predispose to pneumonia after recovery. It has, however, tided many patients over a period of temporary respiratory paralysis, and has thus spared many lives.

After-care in poliomyelitis is important. Massage is valuable in maintaining the circulation of involved muscles. It should not be instituted, however, until all pain and tenderness have disappeared from muscles and joints. Diathermy and stimulation by means of the galvanic electric current have been similarly used. Since improvement in muscular tone and function takes place for months and years, local stimulation must be continued until recovery has reached its optimum point. If serious deformities persist, corrective orthopedic measures should not be attempted until four or five years have elapsed.

[*For a bibliography of the procedures discussed in this article, send a stamped, addressed envelope.*—THE EDITORS]

METHODS FOR QUANTITATIVE ESTIMATION OF THE VITAMINS

III. Measurement of Vitamin A Activity

• It was early recognized that vitamin A deprivation in animals resulted in cessation of growth or—if long continued—in the appearance of a characteristic eye condition known as xerophthalmia (1). These two pathologic effects were both utilized in the first methods proposed for quantitative estimation of this essential food factor.

The earliest techniques for determination of vitamin A were similar in that they all first provided for depletion of the body stores of vitamin A of the rat by restriction of the animals to basal rations free from or quite deficient in the vitamin. In the "rat growth" method, the vitamin A activity of the material under assay was estimated by feeding graded dosages to animals depleted of the vitamin (as gauged by cessation of growth) and recording the ensuing growth response (2). In the "curative technique," the incidence of xerophthalmia served as the criterion of vitamin A depletion (3), and vitamin A activity was estimated by determining the dosage of the test material necessary to establish cure of xerophthalmia.

Techniques were also gradually developed which in some instances embodied features of both the growth and curative methods. Still another technique based on the continuous appearance of cornified epithelial cells in vaginal smears—a further characteristic of vitamin A deficiency in female rats—was evolved (4). Further research showed that colorimetric and spectographic methods may be adapted to the estimation of vitamin A activities of specific materials (5).

Of all methods for estimation of vitamin A in foods, the rat growth technique appears to be favored today (6). Gradual improvements and refinements—as well as recognition of the existence of provitamins A—have led to development of the growth method now included in the U. S. Pharmacopeia XI. This method requires that young rats weighing 40 to 50 grams (at an age not exceeding 28 days when placed on a vitamin A deficient ration) shall manifest symptoms characteristic of vitamin A deficiency within a period of 25 to 45 days. Rats properly depleted of vitamin A reserve are assembled in negative control groups receiving no supplement, reference groups receiving graded doses of the standard reference material, and assay groups receiving graded doses of the assay material. During the ensuing period of not less than 28 days, the test animals are fed daily doses of the proper supplements. The body weights of the animals are recorded at frequent intervals during and at the end of the assay period. From the average gains in body weight of rats in the assay and reference groups, dosages of assay and reference materials, and the vitamin A activity of the standard of reference, the vitamin A activity of the assay material is calculated.

Many researches (7) have established that commercial canning procedures are without significant effect upon either the provitamins A or vitamin A in foods. Consequently, the canned varieties of foods noted for their vitamin A activities provide valuable, convenient and economical sources of this dietary essential.

AMERICAN CAN COMPANY
230 Park Avenue, New York, N. Y.

(1) 1913. J. Biol. Chem. 16, 423 and 255.
(2) 1928. J. Biol. Chem. 78, 671.
(3) 1931. J. Dairy Sci. 14, 229.
(4) 1927. J. Biol. Chem. 73, 153.
(5) 1938. J. Am. Med. Assoc. 111, 245.
(6) 1936. The Pharmacopeia of the United States, Eleventh Decennial Revision, page 478.
(7) 1929. Ind. Eng. Chem. 21, 347.
1936. J. Am. Diet. Assoc. 12, 231.
1936. Mass. Agr. Expt. Sta. Bull. No. 338.
1938. Nutrition Abstracts and Reviews, 8, 281.

What phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. Address a post card to the American Can Company, New York, N. Y. This is the fifty-fourth in a series which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

LABORATORY TEST REPRINTS—Reprints of the resume of commonly employed laboratory tests, which was published in July, are now available. You may have your copy by simply sending a stamped, self-addressed envelope. If you wish more than one copy, send five cents for each additional reprint wanted.

R.N.—A JOURNAL FOR NURSES
RUTHERFORD, N.J.

Toys

[*Continued from page* 17]

into interlocking rings. (The average small child, by the way, is delighted to have these chains hung around the room where he can see them.)

Crayons and coloring books are excellent old standbys. It's a good idea, however, to recommend that *small* books be purchased for the *small* child. For one reason, space in the crib is usually limited. Also, a weak child becomes fatigued if his book is large and awkward.

A tiny marionette for the child to pull up and down on the side of the crib can be made with a tongue-depressor body, applicator arms, and a cotton-ball head, all held in place with adhesive. A dress and bonnet of gauze tied to the doll with one-inch bandage, or fastened with rubber bands, make her complete. A tongue depressor tied to the string from which the marionette hangs, will weight the string so that the child can let go of it and reach it again at will. Very young children—and older ones too—will amuse themselves for hours, making the doll dance.

Some don'ts—

Don't give the small convalescent more than one toy at a time. He tires quickly when the bed is cluttered with a variety of playthings. Children usually concentrate best on a single object. To avoid restlessness and irritability, one book, one toy is the best rule.

Don't be over zealous in an attempt to keep the child amused. Encourage his efforts, help him when necessary. But let *him* do the playing. His transition from sick-room to normal home life will thus be simplified.

Don't forget that most family budgets are heavily taxed when illness comes. Under ordinary circumstances don't recommend expensive toys. Carefully selected cheaper toys and improvised ones can be just as entertaining and constructive.

First prize $25

Plus an unlimited number of $15 $10 and $5 prizes

Win one of these

CASH AWARDS

Can you write? Have you a story to tell?

• Things happen to you every day in the year, don't they. In fact, no other career is quite so full of drama and adventure as is nursing. No other career makes quite so many demands on the individual. Or offers so many rewards.

What has been your experience? What problems have you met and solved? What unusual posts have you held? What ideas have you that would be helpful to other nurses?

R.N.—A JOURNAL FOR NURSES will award a first prize of $25 in cash for the best article by a nurse on any topic pertaining to the personal or economic aspects of nursing. (No medical or scientific material will be accepted.) For all other articles deemed suitable for publication, cash prizes of $5, $10, and $15 will be awarded. The amount of the prize will depend upon the judges' evaluation of the article.

The purpose of the contest is to stimulate constructive thought and to develop practical information which may benefit the entire profession. Articles may either be signed or anonymous, length not to exceed 1500 words. Manuscripts should be typed, triple-spaced, and written on one side of the paper only. None will be returned.

The editors of R.N.—A JOURNAL FOR NURSES will select the winners and notify them by mail. There is no limit to the number of articles you may submit. All manuscripts, however, must be received by noon, February 15, 1940. Address entries to the Contest Editor.

R.N. A JOURNAL FOR NURSES • RUTHERFORD, N. J.

ACIDOLATE

Has An Almost NORMAL SKIN pH

A NEW High Molecular Weight —"Water-Soluble" Oil Detergent

The advantages of having a cleansing agent closely approximating that of the normal skin pH was shown in patch tests by Blank and others. High molecular weight of the fatty acids is desirable to lower skin irritation. Also, it was found that even the non-irritating fatty acids in contact with the skin at higher pH levels may cause irritation.* ACIDOLATE combines the advantages of both the high molecular weight and the normal pH range of the skin.

This *water-soluble* detergent contains none of the common allergens found in many soaps (perfumes or dyes). Dermatologists and physicians will want to try it in conditions where the use of ordinary soaps is contra-indicated. ACIDOLATE has also been used successfully to remove salves and ointments and to cleanse skin areas in cases of simple and atopic dermatitis.

NOPCO

HARRISON, N. J.

*Archives of Dermatology & Syphilology—39:811:1939.

NATIONAL OIL PRODUCTS CO. RN-12
Harrison, New Jersey
Yes, Please send me free of Charge Literature and Full Size Market Package of ACIDOLATE.

*Name*_____

*Street*_____

*City*_____ *State*_____

Interesting products

What is your "I.Q." on new products and services? Here is a ready check-list to keep you up-to-date. You may have samples or literature by writing the manufacturers whose products are described on this page. Be sure to give your registration number, however. The service is available only to registered nurses.

LAUNDRY AID: Do you "do" your own caps? They'll stand up for many a day if you use QUICK ELASTIC STARCH. It doesn't "gum up," or stick to the iron, and your cap will look crisp, without being stiff as a board. Follow the directions on the box, and use a hot iron for pressing. Your patients will find this starch valuable too, for general laundry purposes. Address Dept. RN 12-39, Elastic Starch, Keokuk, Ia. for free test sample.

BABY CLOTHES: You're "in the know" about babies, so you might drop a word to prospective parents. They'll ask you what to buy and how much. Perhaps you can tell them that VANTA baby garments have already won the approval of many nurses and mothers. The garments are sensibly designed, and are said to wear until they are outgrown. No pins or buttons. For a helpful booklet, write to Dept. RN 12-39, Vanta Baby Garment Co., 1333 Broadway, New York, N.Y.

SKIN PROTECTOR: Cold, windy weather ahead—you'll need to take extra care of your skin. ARMAND blended cream is a modernized, non-greasy cold cream for cleansing. ARMAND cold cream powder contains a bit of the finest cold cream to protect the skin against drying. Send three cents in stamps for purse-sized trials to Dept. RN 12-39, The Armand Co., Des Moines, Ia.

HEALTH DRINK: Did the doctor order a high caloric diet? Try JOYANA, a new vitamin health drink. Made with soy bean, wheat germ, barley malt, and rice coatings, it provides five vitamins, A, B_1, B_2, C, and D. Try it with milk three times a day, for many of your nutritional requirements. For samples, write Dept. RN 12-39, Enrich Products, Inc., 67 Vestry St., New York, N.Y.

COFFEE: Suppose you're devoted to coffee, but can't take caffein. Well, here's good news: According to the Council on Foods of the American Medical Association, SANKA coffee is free from caffein effect, and "can be used when other coffee has been forbidden." Write for generous trial portion. Dept. RN 12-39, General Foods, Inc., Battle Creek, Mich.

ANODYNE: Have you noticed that the nurse is supposed to be a "General Information Bureau" on matters physical and medical? Next time anyone asks you about "cramps" and menstruation, tell them about the free booklet put out by the makers of MIDOL, a medicine for the relief of functional periodic pain. This pamphlet provides a summary of up-to-date information on menstruation. For your copy, write to Dept. RN 12-39, General Drug Co., 170 Varick St., New York, N.Y.

VITAMIN FACTS: The newest facts on vitamins are hard to get, because the information changes from month to month, as new research reports come in. The PHYSICIANS' VITAMIN REFERENCE BOOK is up-to-the-minute. Students may use it for classroom reports, for information too recent to be found in textbooks. For the graduate, it is a handy reference manual which sums up the *whole* vitamin story. It will be sent free to the first thousand readers who request it. Address Dept. RN 12-39, E. R. Squibb & Sons, 745 Fifth Ave., New York, N.Y.

Classified

There is no charge to registered nurses for the use of this department. To apply for a "position available," simply outline your qualifications in a letter. Address the letter to the correct box number care of R.N.—A JOURNAL FOR NURSES, *Rutherford, N. J. (Send no money with your application. If the bureau requires a registration fee, it will bill you separately.) Submit "positions wanted" early. They will be published in the order received.*

POSITIONS AVAILABLE

***ADMINISTRATOR:** Midwest. For position in small hospital. Must be able to administer anesthetics. Preference given to mature Protestant. Salary, $110 and full maintenance. Box C875.

***ANESTHETIST:** California. For position in small Catholic hospital; seaside location. Must be willing to build up department; do some surgery and general duty. Salary open. Box W93.

***ANESTHETIST:** California. Position of second anesthetist and surgical nurse in 100-bed private hospital. Salary, $125 and maintenance. Box W94.

***ANESTHETIST:** Midwest. Tact and personality necessary for office appointment. Applicants under 35 preferred. Salary, $150. Box C876.

ANESTHETIST: New York State. Willing to combine with supervising duty. Salary, $110 and maintenance. Box LAD, 12-39.

***CLINIC SUPERVISOR:** Southwest. For out-patient department in large hospital. Requires special training in public health, as duties involve some teaching in this subject. Salary, $125. Box C877.

***DAY FLOOR-SUPERVISOR:** South. Opportunity for advancement to more responsible position. Duties involve supervision of students. Salary open. Box C878.

***DIRECTOR OF NURSES:** East. Protestant, at least 35, for all-graduate staff, progressive hospital. Desirable location. Tentative salary, $135 and full maintenance. Box C879.

***GENERAL DUTY:** California. Private 100-bed hospital; good living and working conditions. Salary, $75 and maintenance. Box W95.

***GENERAL DUTY:** Indiana. To scrub in surgery, in 85-bed hospital. Eight-hour duty. Salary, $70 and maintenance. Box C881.

***GENERAL DUTY:** Midwest. Post-graduate work in obstetrics necessary for position in new 75-bed hospital. Opportunity for advance to supervisory post as department grows. Approximate starting salary, $85 and full maintenance. Box C880.

GENERAL DUTY: Utah. Night duty, including surgery and obstetrical nursing, small private hospital. Salary, $70 maintenance. Box SWG, 12-39.

***HEAD NURSE:** South. Catholic preferred for 23-bed medical and surgical floor. Salary, $90; early advancement. No maintenance. Box C883.

***INSTRUCTOR IN THEORY:** New England. For position in hospital. Salary, $115 and maintenance. Box C884.

***LABORATORY TECHNICIAN:** South. Must be graduate nurse, for position in office of two physicians. Duties will include office assisting. Salary open. Box C882.

***MEDICAL SOCIAL-WORKER:** Registered nurse, with degree in sociology or public-health work. Duties involve interview and follow-up work to indigent patients, case work on crippled children. Salary, $150. Box C885.

***OBSTETRICAL NURSE:** California. Preferably someone with DeLee technique for night duty in small hospital. Salary, $100 and meals. Box W96.

***OBSTETRICAL NURSE:** California. Post-graduate course in obstetrics necessary for position in approved, 100-bed hospital in suburban San Francisco. Box W97.

***OBSTETRICAL SUPERVISOR:** South. Catholic preferred for position in large hospital. Starting salary $110, advancement assured if satisfactory. Box C888.

***OFFICE NURSE:** East. Must be qualified in medical laboratory technique, physical therapy, and stenography, for position in office of physician. Salary fairly good to start; possibility of increases. Box C889.

***OFFICE NURSE:** South. For position as assistant to physician. Some knowledge of simple business affairs decided advantage. Salary open. C890.

***OPERATING ROOM NURSE:** Midwest. To take charge of operating room, supervise central service rooms in new hospital. Protestant. Salary, $85 and maintenance. Box C886.

***PSYCHIATRIC SUPERVISOR AND INSTRUCTOR:** For position in affiliate school of large State hospital. B.S. degree, psychiatric experience, ability to work well with others required. Salary, $1500 and full maintenance. Box C891.

***RECORD LIBRARIAN:** Michigan. Graduate nurse, to assist superintendent of 50-bed hospital. Salary open. Box C892.

***SCIENCE INSTRUCTOR:** East. College degree required for position in large metropolitan hospital. Salary dependent upon qualifications. Box C893.

***SUPERINTENDENT:** California. For position in small, privately owned hospital. Must have recent executive experience, be broadminded and progressive. Salary, $150 and maintenance. Box W98.

***SUPERINTENDENT:** New York registration, experience required for position in small, well established hospital. Ability to take X-ray pictures advantageous. Salary, $1700 and full maintenance. Box C894.

***SUPERINTENDENT:** Washington. For position in 100-bed institution, owned by medical group. Good business ability and executive experience essential. Salary, $150 and maintenance. Box W99.

***SUPERINTENDENT OF NURSES:** Louisiana. College degree required for position in hospital. Must be mature. Prefer southern nurse. Salary, $150 and full maintenance. Box C895.

***SUPERVISOR:** California. University background or experience preferred for obstetrics position in charge department of large hospital. Salary, $140 and meals. Box W100.

***SUPERVISOR:** California. Pediatrics. Position open January 1, 1940 for teaching-charge nurse in 25-bed pediatric department, large county hospital. Fifteen units of education from approved university required. Salary, $115 plus board and laundry. Box W101.

***SUPERVISOR:** Midwest. Excellent preparation and experience required for position in medical-surgical ward of 100-bed hospital. Vicinity Chicago. Salary, $80 and maintenance. Box C896.

***SURGICAL NURSES:** California. Two nurses for 100-bed private hospital in San Joaquin Valley. Salary, $85 and maintenance, nights; $80 and maintenance, days. Box W102.

***SURGICAL NURSE:** Indiana. Post-graduate course in surgery required for position in 200-bed hospital. Very desirable, convenient location. Salary, $90, board and laundry. Box C887.

***SURGICAL SUPERVISOR:** Illinois. Pleasant hospital offering excellent working conditions. Salary depends entirely upon qualifications. Box C897.

POSITIONS WANTED

ANESTHETIST: Member of Nat'l Assoc. Nurse Anesthetists; experienced in administration of ether, cyclopropane, nitrous oxide, avertin. Protestant; age 37. Fair typist. Prefers position on Pacific Coast. Box 129-1.

COMPANION NURSE: For semi-invalid, or elderly woman who wishes to travel. Registered in New York, New Jersey, and Florida. Best references. Salary open. Box 129-2.

GENERAL DUTY. Graduate of accredited nursing school; registered Pennsylvania and New York. Experienced in general and private duty, as charge nurse, and as relief supervisor. Box 129-3.

GENERAL DUTY: Graduate of 200-bed general hospital. In general and private duty for 10 years. Age 31. South Carolina registration. Prefers Florida. Box 129-19.

GENERAL DUTY: Recent graduate. Registered in Iowa. Prefers position in Catholic hospital in Iowa, or other section of Midwest. Box 129-4.

GENERAL DUTY: Registered in Ohio and California. Seven years' general staff experience. Protestant; age 30. Good health. Box 129-5.

HEAD NURSE: Or general duty. Graduate of Bayonne Hospital and Dispensary; New Jersey registration. Age 26. Prefers position in New York City or Jersey City; salary, between $80 and $85, with full maintenance. Box 129-6.

INDUSTRIAL NURSE: Some experience in public health and clinical work. Also business training. Four years' experience as general duty nurse and ward supervisor. Prefers vicinity of New York City. Salary open. Box 129-20.

INDUSTRIAL: Or welfare work, in mining town or mountain section. Registered in South Carolina and Florida. Age 45. References furnished if requested. Box 129-8.

INSTRUCTOR: Desires position as ward teacher, or as assistant superintendent of nurses. B.S. degree; 8 years teaching experience. Prefers California location. Box 129-23.

MALE NURSE: Experienced in clinical, industrial, operating room, supervision, genito-urinary, cystoscopic, and private-duty nursing. New York registration. Box 129-24.

OBSTETRICAL SUPERVISOR: Post-graduate work in infant care; 9 years' experience. Minimum salary $100, with full maintenance. California registration. Age 31. Prefers position on West Coast, or in Midwest. Box 129-10.

OFFICE NURSE: Registered in Pennsylvania. Experienced in private and general duty; secretarial training. Age 24. Prefers position in western Pennsylvania. References available. Box 129-12.

OFFICE NURSE: Michigan and Indiana registration. Age 27. Salary open. Prefers position in Michigan. Box 129-11.

PRIVATE DUTY: Several years experience in private duty and public health field work. Single; willing to locate anywhere. Excellent references. Box 129-25.

SCHOOL NURSE: Desires position as nurse in boys' or girls' school. Experienced in care of children. Illinois registration. Single. Age 25. Box 129-26.

SUPERINTENDENT: Former nurse supervisor in tuberculosis sanitorium. Registered in Missouri, Michigan, and Pennsylvania; college education. Age 44. Excellent references. Box 129-27.

SUPERVISOR: In medical or surgical nursing. Registered in Pennsylvania and West Virginia. Experienced; knowledge of laboratory routine, X-ray, and physiotherapy. Box 129-15.

SUPERVISOR: On surgical or obstetrical wards. Fourteen years' experience; New York registration. Desires position in or around Los Angeles. Box 129-16.

SUPERVISOR: Or industrial nurse. Experienced in general duty, private duty, and in tuberculosis sanatorium. Age 23; Protestant. References available. Box 129-28.

SUPERVISOR: For a 50-bed hospital. Also able to do operating-room work. Registered in Ohio and New Jersey. Box 129-21.

SUPERVISOR: On tuberculosis or psychiatric ward. Graduate nurse; Alabama registration. Three years of college. Prefers position in Western hospital. Box 129-17.

SURGICAL NURSE: Or general duty. Rhode Island registration. Experienced as assistant operating supervisor; also surgical, general, and private duty. Desires position in Florida. Box 129-18.

SURGICAL SUPERVISOR: Postgraduate work in surgery at Johns Hopkins. Has had 8 years' experience. Desires position in California. Excellent references. Box 129-22.

"Is it true —"

[*Continued from page* 19]

They'd know that hot coffee is to the night nurse what the St. Bernard dog and his quota of brandy are to the half-frozen traveler in the Alps.

Those are only isolated examples of what I mean. But I had a real dose last week when I made a speech at a mother-daughter banquet. I talked about nursing as a career. At the finish questions were invited, and what questions they turned out to be! One matron, cultured, educated, obviously well informed, was interested in her daughter's choice of a future. "Tell me," she asked, "is it true that student nurses have to scrub floors?"

We settled that and gave the floor to an elderly spinster. "My niece is determined to become a nurse. We have done *everything* to dissuade her. Both her mother and I have looked into the matter carefully. We have seen every motion picture that has treated of hospitals. Frankly, we have come to the conclusion that the so-called schools of nursing are a definite moral menace. Really, do motion pictures give an honest portrayal of nursing education?"

A girl with horn-rimmed glasses and a severe hair-do asked brightly, "Does the average nurse - er - marry a doctor?"

It was a strain on my platform manner not to say, "The *average* girl, my pet, marries no one!"

The climax came when a sweet young thing arose. "I'm in high school. I've always wanted to be a nurse. Even when I was a child I used to play that my dolls were sick. But I've been wondering . . . Could a person be a nurse—I mean couldn't a nurse do all right and—and—well, not have to wait on people when they couldn't do things for themselves—I mean, like bedpans?"

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Sick room odor may be due to stale perspiration odors. Patients often feel grateful when you help eliminate this depressing factor by giving them a personal "air-conditioning" with MUM. This snow-white cream deodorant quickly neutralizes stale perspiration odors. Use MUM—the new form of personal "air-conditioning"—regularly on patients. And to make it unanimous, use MUM yourself.

MUM **Takes the Odor out of Stale Perspiration—Does Not Interfere with Normal Sweat Gland Activity. Have you learned how elegantly MUM subdues sanitary napkin odors?**

A BOXFUL OF FRESHNESS—A dab of soothing MUM, applied to underarms and other skin areas, maintains personal freshness by banishing stale perspiration odors. Quick, non-irritant; does not stain clothing or bed linens.

Personal "air-conditioning" as herein used applies to the removal of stale perspiration body odors which occasionally permeate an office or room.

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WHO IS GLAD TO CARRY OUT DOCTOR'S ORDERS

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